MacDonald Naturopathic Medical Clinic

Dr. Crista MacDonald-Werby, BHSc., ND – Doctor of Naturopathic Medicine

29 Wellington Street North, Woodstock, Ontario N4S 6P4

Tel: (519) 539-7000

Dear

Thank you for booking an appointment at the MacDonald Naturopathic Medical Clinic! As discussed, we have included a detailed health intake questionnaire and consent forms. Please bring the completed questionnaire and forms to your appointment, as well as any supplements you are currently taking, and a copy of any lab or blood work that has been performed within the past year (your medical doctor/specialist can supply you with a copy of your lab results if you ask him/her).

Your appointment information is as follows:

Date:
Time:

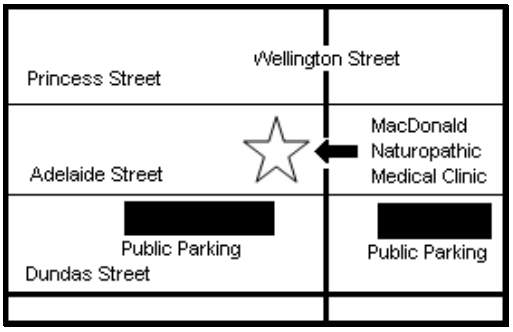
The MacDonald Naturopathic Medical Clinic is located at 29 Wellington Street North. There is plenty of free parking in the public parking lots along Adelaide Street.

The initial appointment will be 1¼ hours in length and will consist of a thorough health intake. Follow-up visits are generally 30 minutes in length. The cost of the initial appointment is $160. The second appointment and all follow-up appointments are $77. Payment is made on receipt of treatment. ***We accept cash, cheque and debit.*** Naturopathic medical services are covered by most extended health insurance plans. *Direct benefit submission is available to some Benefit Providers.* Please check with us for more information.

If you have any questions please feel free to contact our office at (519) 539-7000. We look forward to working with you in achieving your health goals!

Wishing you good health,

Dr. Crista MacDonald-Werby, ND



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PATIENT INTAKE FORM - ADULT

Name:_____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone (H): _____ (Bus.): _____ (Cell): _____
E-mail: _____
Male: ❒ Female: ❒ Date of Birth: _____
Occupation: _____
Marital Status: _____ Number of children: _____

Food or Drug Allergies: _____
Environmental Allergies: _____

Emergency Contact: _____Phone:_____Relation:_____
Name of Medical Doctor: _____ Phone: _____

How did you hear about us?
❒ Newspaper ❒ Website ❒ Friends ❒ Family ❒ Other:

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main health concerns in order of importance to you?

_____
_____
_____
_____
_____

Vitamins and Supplements

Are you taking any vitamin/mineral/herbal supplements? Y N
If yes, please list the supplement(s) and the dosage:

Supplement/Vitamin	Reason for taking	Dosage

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

Prescription Drug	Dosage	When did you begin this medication?

Please list all over-the-counter medications you have taken in the past year:

_____

_____

_____

How many times have you taken antibiotics?

_____

Family History

Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	**Diseases Suffered/Cause of Death**
Father	
Mother	
Brother(s)	
Sister(s)	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Uncles	
Aunts	

Medical History

List any major surgery or injury and when it happened:

_____

_____

List any major illnesses or diseases that you have/had:

_____

_____

_____

_____

_____

_____

Chemical, Heavy Metal and Toxin Exposure

Please circle the chemicals, toxins and/or heavy metals that you have been exposed to:

Second Hand Smoke	Cleaning Products	Mercury
Pesticides	Asbestos	Aluminum
Herbicides	Radiation	Lead

Vaccinations (please check)

- ❑ DPT (Diphtheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other _____

Did you experience any adverse effects from them? If yes, please explain

_____

_____

Present and Past Health Symptoms

Please check "√" if you are experiencing the following symptoms or write 'P' beside the box if you have experienced these symptoms in the past.

General

- ❑ Change in appetite
- ❑ Nervousness
- ❑ Weight gain
- ❑ Weight loss
- ❑ Cancer
- ❑ Diabetes
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Allergies
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Heavy perspiration
- ❑ Cravings
- ❑ Strong thirst

Eyes Ears Nose Throat

- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Headaches
- ❑ Loss of taste/smell
- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Vertigo
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth

Skin and Hair

- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Hair loss
- ❑ Excess hair
- ❑ Dandruff
- ❑ Change in mole(s)
- ❑ Dryness
- ❑ Hives
- ❑ Boils
- ❑ Bruising/bleeding

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke
- ❑ Pacemaker or device
- ❑ Artificial valve
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Joints

- ❑ Neck or Back pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain
- ❑ Artificial joint(s)

Gastrointestinal

- ❑ Abdominal pain
- ❑ Heart burn
- ❑ Nausea
- ❑ Vomiting
- ❑ Indigestion
- ❑ Bloating
- ❑ Burping
- ❑ Bad breath
- ❑ Gall bladder stones
- ❑ Jaundice
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movements
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Gas
- ❑ Intestinal worms

Infections

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV/AIDS

Neurological

- ❑ Loss of balance
- ❑ Poor memory
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Loss of sensation
- ❑ Muscle weakness

Kidney and Bladder

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Bladder infection
- ❑ Blood in urine

Male

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Pain with erection
- ❑ Pain on ejaculation
- ❑ Difficulty conceiving
- ❑ Sexually transmitted infection
- ❑ Hernia
- ❑ Do you perform regular testicular exams? Y N

Female

- ❑ Irregular periods
- ❑ Heavy periods
- ❑ Light periods
- ❑ Clotting
- ❑ Painful period
- ❑ PMS
- ❑ Vaginal discharge
- ❑ Difficulty conceiving
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ Sexually transmitted infection

Age of first menstrual period? _____

Date of last Pap _____

Do you perform regular breast exams? Y N

Pregnant? Y N

Number of:

- Pregnancies _____
- births _____
- abortions _____
- miscarriages _____

Menopausal: Y N
Age of last menses _____

Sexual Health

Are you sexually active? Y N

Do you use birth control? Y N

Type_____

Emotional

- ❑ Irritable
- ❑ Anxiety
- ❑ Depression
- ❑ Frequent "ups and downs"
- ❑ Stress
- ❑ Anger
- ❑ Other _____

Please rate your level of stress from 1 (low stress) to 10 (high stress):

1 2 3 4 5 6 7 8 9 10

Do you generally feel satisfied with your home life? Y N

Do you generally feel satisfied with your work life? Y N

Do you feel overworked? Y N

Do you have friends or family who you can turn to for support? Y N

What do you enjoy doing in your spare time (hobbies, activities, etc)?

_____
_____
_____
_____

Do you take regular vacations? Y N

Personal Habits and Lifestyle

Do you smoke? Y N If yes, how many cigarettes per day? _____
Do you use recreational drugs? Y N If yes, type of drug:_____

How frequently do you move your bowels? _____ (per day or per week)

How many hours of sleep do you get on average per night? _____
Do you feel refreshed upon waking in the morning? Y N

Do you exercise? Y N If yes, how often?_____
What do you do for exercise?

_____
_____

Diet

How many cups/bottles/glasses do you drink on average per day?

Coffee		Milk		Fruit Juice	
Black Tea		Liquor		Soft Drinks (diet)	
Water		Beer		Soft Drinks (regular)	
Herbal Tea		Wine		Other: _____	

Diet: Non-Vegetarian ❒ Vegetarian ❒ Vegan ❒ For how long? _____

Do you consume (circle): Aspartame MSG Trans-fats/Hydrogenated oils BBQ-ed foods

Known Food Allergies/Food Sensitivities: _____
_____

Please describe a typical day's diet:
Breakfast _____

Lunch _____

Dinner _____

Snacks _____

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Thank you for taking the time to fill out this questionnaire. It will allow us to assess your past and current state of health and it will help us to better understand your health goals.

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Health Consent Form

NOTE TO PATIENT: *We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question about any of this, please ask.*

CONSENT TO EXAMINATION AND TREATMENT

I would like to take this opportunity to welcome you to the MacDonald Naturopathic Medical Clinic. Naturopathic Medicine is a distinct primary health care system that blends modern scientific knowledge with traditional and natural forms of medicine.

At the MacDonald Naturopathic Medical Clinic, treatment approaches can include any combination of: Clinical nutrition, Botanical (herbal) medicine, Acupuncture, Asian Medicine, Homeopathic medicine, Physical therapeutics, Hydrotherapy, and Life-style counseling.

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of informed consent. In so doing you understand that:

1. I, Crista MacDonald-Werby, ND, am a Naturopathic Doctor, and not a conventional medical doctor. Naturopathic Medicine is the art and science of disease diagnosis, treatment and prevention using non-invasive natural therapies tailored to each patient and their individual health concerns.
2. The methods I use may have a proven clinical foundation and/or a proven scientific foundation, yet may not be accepted by standard (allopathic) medicine.
3. I am required by my licensing board to perform a physical examination on each new patient. A physical examination will allow me to better understand your unique state of health.
4. Referral to other health professionals will be made as necessary. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider while under care at the MacDonald Naturopathic Medical Clinic.
5. While changes in dietary habits are not an absolute prerequisite for treatment, you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
6. You are accepting or rejecting this care of your own free will.
7. All fees for services and supplements are to be paid at the time of the appointment by the patient or the guardian. **There is a fee for completing insurance forms, letter writing and telephone consultations of greater than 10 minutes. Notice of 24 hours (in person or by telephone – NO emails please) is required for appointment cancellation, otherwise you will be charged an administrative fee of $50.00.**

CONSENT FOR THE COST OF OUR SERVICES

Initial appointment (1 ¼ hours)	$ 160
Follow-up appointment (30 minutes)	$ 77
Quick appointments (15 minutes)	$ 45
Home visits (30 minutes)	Appointment cost + $20 travel

Health products (if needed) are in addition to the cost of the visit (prices vary).
Laboratory test fees (if needed) are in addition to the cost of the visit (prices vary).

I, _____ have read and understood the above statements regarding *Consent to Examination and Treatment* and *Consent for the Cost of our Services*.

SIGNATURE _____ DATE: _____
(Patient or guardian)

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with naturopathic services, the MacDonald Naturopathic Medical Clinic will collect some personal information about me (e.g., home telephone number, address, past and present health history, etc.).

The MacDonald Naturopathic Medical Clinic's Privacy Policy is several pages long. A copy of the Privacy Policy is always available at the clinic's reception desk. Do not hesitate to discuss our policies with the clinic owner, Crista MacDonald-Werby, ND.

I have reviewed the MacDonald Naturopathic Medical Clinic's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask questions about the Privacy Policy and they have been answered to my satisfaction.

I understand that **only if I check off** the following boxes will I receive the following:

- ❑ I would like to receive notice when it is time to review whether I need another appointment.
- ❑ I would like to receive newsletters and other informational mailings or emails from the MacDonald Naturopathic Medical Clinic.
- ❑ I would like to receive notice of promotions and/or seminars or workshops offered by the MacDonald Naturopathic Medical Clinic

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I agree to the MacDonald Naturopathic Medical Clinic collecting, using and disclosing personal information about me as set out above and in the MacDonald Naturopathic Medical Clinic's Privacy Policy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NATUROPATHIC DOCTOR: _____